DOCUMENT RESUME

ED 161 805 SO 011 280

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TITLE Some Latent Effects of Current Social Policies on the Elderly.
PUB DATE Sep 78
NOTE 15p.; Paper presented at Annual Meeting of the American Sociological Association (San Francisco, California, September 4-8, 1978)

EDRS PRICE MF-$0.83 HC-$1.67 Plus Postage.
DESCRIPTORS Federal Aid; *Federal Programs; Health Programs; Housing; Life Style; Medical Services; *Policy Formation; Program Evaluation; Retirement; *Senior Citizens; *Social Problems
IDENTIFIERS Medicaid; Medicare; Social Security Benefits

ABSTRACT

Current social policies for the elderly are intended to assure a better standard of living, promote adequate medical treatment, and assure safe and clean housing, but they have unintended consequences. It is argued that these social policies serve to keep older people in a state of dependency, poverty, and segregation. Some social policies may be based on two assumptions: (1) disengagement theory, which provides a supposedly healthy adjustment to change in the life cycle by stressing decreased social roles of the elderly, and (2) activity theory, which limits the activity and engagement of the elderly in their social roles. Three federal programs for the elderly are cited and illustrate the manifest or intended functions and the latent or unintended functions of social policy. The Social Security Benefits Program is intended to help elderly citizens meet their basic needs. Yet the retired worker with an income of $100,000 from investments can receive the full benefits from the program, while a worker who hasn't accumulated the necessary savings to assure an adequate income after retirement may be penalized for working. Medicare and Medicaid programs have the intent of independence without the burden of high medical costs. Yet the policies encourage dependency and assist the nursing home industry. The federal housing programs have discouraged exploration of other housing alternatives to single-home residences. The author concludes that more attention should be paid to the latent consequences of programs for the elderly. (Author/MR)

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SOME LATENT EFFECTS OF CURRENT SOCIAL POLICIES ON THE ELDERLY

by

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SO-011280

September 1978

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Paper presented at Annual Meeting of the American Sociological Association (San Francisco, California, September 4-8, 1978)

INTRODUCTION:

Discussions of the problems of the aging often overlook the fact that current social policies, especially those affecting programs administered by the Federal government, may not deliver the benefits which they claim, but may, instead, serve to keep older people in a state of dependency, poverty, and segregation.

Robert K. Merton (1957) used the term "social function" to refer to the extent to which some part or process of a social system contributes to the maintenance of that system, or promotes or interferes with such system maintenance. He further distinguished between two forms of "social function:" 1) manifest function was defined as the intended or anticipated outcome or consequence of the function; and 2) latent function which was defined as unintended or unanticipated outcome of some such social process.[1]

Within this conceptual framework of manifest and latent consequences, this paper is an examination of three programs for the elderly: the Social Security Benefits program, Medicaid and Medicare programs, and the various housing programs for the elderly adminstered by the Department of Housing and Urban Development. (HUD)

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[1]Merton defined social function as "...observable objective consequence,...not subjective dispositions (aims, motives, purposes)." Further, in his example of the Hopi Indian rain ceremony, he appears to stress those latent functions, that though unintended, did in fact, contribute to system maintenance.

The stated goals of these programs are to provide a better standard of living, adequate medical treatment, and safe and clean housing for elderly beneficiaries. There can be little argument with the provision of such services for our older population, but as this paper will demonstrate, rather than ameliorating the conditions of the elderly, the social policy implications of these three programs have been detrimental to the ability of older people to maintain independent and quality life styles.

For purposes of this paper, the term elderly or older person will refer to those persons, 62 years of age and older in the case of females, and 65 years of age and older in the case of males, the ages at which these people are eligible for benefits under the rules and regulations of the programs discussed.

CURRENT THEORIES, IMPACT ON POLICY:

A number of current theories appear to serve as the rationalization for some of the social policies under discussion. One of these is the approach embodied in the "disengagement theory" model of Cumming and Henry. (1961) According to this approach, growing old involves a gradual and "inevitable mutual withdrawal or disengagement, resulting in decreased interaction between an aging person and others in the social system he belongs to." (Cumming and Henry, 1961:14) Society and the individual prepare in advance for the ultimate disengagement

of death by this "inevitable" and mutually satisfying process of social disengagement prior to actual death. The individual reduces the number of roles played, limits the variety of and at the same time weakens the intensity of those roles and relationships which remain. Society in turn offers the individual freedom from structural constraints and "permission" and encouragement (such as forced retirement) to withdraw. As the theory is presented, it is a consequence of the "healthy" adjustment of the older person to changes in life's cycles.

Although there is difficulty in interpreting the loss of roles in old age, there is little evidence that suggests that all aging persons willingly take the initiative in "disengagement." However, some of the policies implemented as part of the programs under discussion may make disengagement the only practical alternative available. Thus social policy creates an empirical basis for a theory which does not raise the question of which came first, disengagement or policy?

The other theoretical approach that has developed in response to disengagement theory is "activity theory." (Havighurst, 1964; Clark and Anderson, 1967; and others) The basic postulates of this theory are 1) the majority of normal aging persons maintain farily level amounts of activity and engagement; 2) the amount of engagement-disengagement is more influenced by past life styles and by socio-economic factors and forces rather than by any intrinisic and/or inevitiable process; and

3) maintaining or developing substantial levels of physical, mental, and social activity is usually necessary for successful aging.

Rosow (1967) attributed the opportunities to associate with age peers as a correlate of social interaction and life satisfaction, and he hypothesized that the "most viable opportunities for the integration of older people in informal groups are among their age peers." Current social policy encourages this age-segregation by building activities around special senior citizen centers.

The following discussion of the policy implications of current social programs illustrate how the two theoretical approaches embodied in disengagement and activity theory became fact, and how such programs, designed specifically for old people, have tended to segregate them both socially and physically from other age groups.

SOCIAL SECURITY BENEFITS:

The initial intent of the Social Security Act of 1935 was to provide: 1) a base for "income maintenance" in old age; 2) a similar floor or base for disabled breadwinners; and 3) a minimum support for dependents of deceased breadwinners. Through the 40 years of its existence the Social Security Act has been updated to include almost all workers, and in 1972 the Social Security Administration took over the administration of the benefits formerly supplied through Aid to the Needy Disabled,

Aid to the Blind, and aid to those aged persons who were not formerly covered under previous provisions. (Supplemental Security Income Act, or SSI)

The program was originally proposed as a base, meeting only minimal needs. It did not, and does not provide an adequate standard of living for those who are dependent on these benefits as their only source of income. Benefits are calculated on the basis of the worker's past earning history with the minimum benefit paid to a single worker in 1977 set at $107.90 per month; the maximum benefit paid was $412.70. The average payment was $232.71; under the SSI program the average payment was $218.00. Workers who have wives 65 years of age or older receive an increased benefit amounting to 50% of their benefit. Since men traditionally have earned more than women, it is usually the woman who elects to take the spouse's benefit. Workers who are forcibly retired prior to age 65 receive a reduced benefit, as do widows who are at least 60 years of age, but less than 65. Such reduced benefits remain in force for the remainder of the beneficiary's lifetime.

The 1977 Poverty Guidelines set the poverty level at $242.50 for single individuals, and $305.80 for two-person households headed by an elderly person. Thus, given the average Social Security benefit paid, it is not surprising that although the elderly represent approximately 10% of the population, they constitute more than 25% of those people who fall below the poverty line.

The retirement test provisions of the Social Security Act serve in many cases to keep those most in need of extra income, poor. Under these provisions, benefits are not paid in full to a beneficiary under age 72 who has earnings from wages which exceed the annual exempt amount ($2,760 in 1976). An older worker, who is able to secure employment has $1.00 in benefits withheld for each $2.00 of earnings in excess of the ceiling. The retirement test applies only to wages, and not to income derived from other sources such as investments. Thus, the retired worker with an income of $100,000 per year which comes from investments may still receive his or her full benefits, while the worker who has made the least during his/her lifetime, and thus receives the lowest benefit, is penalized for working.

In effect, the poor are penalized twice: first, when working, they pay a higher proportion of total income into the Social Security fund, usually being subject tc the full 6% on all their income, while those who had incomes of $30,000 paid approximately 3% of their total income into the fund. (Until recently the tax was applied to the first $15,000 of income; since most poor workers made less, they paid the full 6% on their total income). For those who had income primarily from investments and not wages, the disparity is even greater. Secondly, the poor are the most likely to bear the brunt of the retirement test, having been unable to save sufficiently to ensure an adequate income from investments on their retirement from active work.

MEDICARE AND MEDICAID:

"Medicare is a health insurance program for people over 65, and some people under 65 who are disabled...(it) can help pay for medically necessary inpatient hospital care, and after a hospital stay, for inpatient care in a skilled nursing facility and for care in your home by a home health agency...skilled nursing services." (U.S. Department of Health, Education and Welfare, Social Security Administration, 1976; Emphasis added.) It is a co-insurance program, and has limitations on both what is covered, and how much of allowed items it covers. Eye care, dental care, hearing aids, drugs for some of the most common ailments of older people are excluded from coverage. Thus coverage for chronic illnesses, which are not life threatening, such as arthritis, diabetes, emphesema, and angina, is denied outside of the hospital or "skilled nursing care" facility.

The restrictions on home care services preclude such care in order to postpone or prevent the institutionalization of the older person. Household services can only be provided when they are incidental to the health service. Medicare and Medicaid restrictions to the provision of "skilled nursing care service" in home-care programs may indeed force many semi-independent persons to enter nursing homes although they may need only minimal services such as assistance with home chores and shopping.

Medicaid is the insurance program intended to cover the medically indigent person. When an older person has

exhausted the benefits available under the Medicare provisions, he/she may be forced to turn to Medicaid for further care. In order to be eligible, many older people find they must divest themselves of their assets, a kind of enforced pauperization. Utilization of nursing homes has increased by 105% for the over 65 year old group during the years 1960 to 1970. Much of this increase may be due to the lack of options in providing home care and other minimal support services.

Medicare and Medicaid programs had the intent of enabling older persons to maintain their independence without being burdened by the high costs of illness. It would seem that the policies inherent in the administration of these programs are, in fact, encouraging dependency, and helping the growth of the nursing home industry, rather than assisting the elderly in their attempts to maintain independent, non-institutionalized living situations.

FEDERAL HOUSING PROGRAMS FOR THE ELDERLY:

Although there have been programs for building housing for the poor under local housing authorities, it wasn't until 1956 that the elderly were specifically designated as the target population for specific housing programs. Since that time, a myriad of complex, and sometimes confusing, programs have been developed. A discussion of the 1959 Direct Loan Interest Subsidy Program, known as Section 202 of the Housing Act of the Department of Housing and Urban Development, will give some idea of the problems inherent in these programs.

Section 202 provided non-profit sponsors with 100% financing at interest rates o. 3% for the building of housing for limited income older people. Income levels were set at $4,500 for individuals and $5,5000 per couple. Since the buildings were to be self-supporting, people on welfare programs such as Old Age pensions, and those whose only income came from Social Security benefits often did not have enough income to qualify for admission. Those whose income exceeded the upper levels set found that even though they might live in undesireable housing, be unable to maintain homes, or keep up tax payments, etc. were also ineligible. The pattern that became apparent in the Medicare/Medicaid programs operated in this and other housing programs: residents divested themselves of assets in order to qualify for admission. Although all of the housing under this program had some subsidized units where low income residents would have to pay only 25% of their incomes, such units were usually limited to 10% of the total stock available in any building. Thus residents, who did indeed qualify for the subsidies, did have at least the minimum income, were disqualified when a subsidized unit was not available at the time of their admission. The alternative for these people was to seek assistance from other family members, if indeed there were such members available to them.

Section 202, and most of the subsequent housing built under various HUD programs have discouraged the provision of any supportive services, including the provision of space to provide

these services. Even if HEW decided to provide some minimal support services, most of the existing buildings would not have space for such services. Taking away from the available rental stock would jeopardize their ability to be self supporting. The result of this is residents living in constant fear of becoming ill and being forced to move out. The requirements specify the well elderly, able to maintain independent living situations, and such requirements have frequently been rigidly interpreted by managers of the buildings.

There has been little support for those older people who wish to continue to maintain their own homes or apartments. They are faced with ever increasing costs, and as younger people move to the outskirts of the cities, find themselves in increasingly age-segregated or crime ridden areas of the inner cities, with few resources available to them for even minimal services. This, along with the limited home care provisions under the Medicare/ Medicaid programs, and the income levels provided by the Social Security benefits place older people in constant jeopardy and fear of institutionalization. The programs in housing have also served to discourage explorations of other alternatives such as group homes, cooperative units, etc., and benefit the nursing home industry, the governmental bureaucracy, and, in this case, the construction industry. It is indeed profitable to help the elderly disengage.

CONCLUSIONS:

The three programs under discussion have all had the manifest function of increasing and enhancing the quality of life for elderly people. Yet the myriad of regulations and restrictions have instead, served to remove them from the mainstream of American life, created dependency, forced them to live in fear of the future, and thereby has furthered the isolation and impoverishment of this group. Disengagement of the elderly under these circumstances cannot be considered voluntary or natural, and maintaining activities becomes increasingly difficult. It is not aging per se, but a number of factors associated with aging, such as poor health, widowhood, reduced income, etc., which determine or influence disengagement or engagement. One of the barriers existing that prevents full participation or engagement of the elderly is the social policy inherent in the three programs discussed.

To change this situation, more attention needs to be paid to the policy implications of various programs for the elderly, with special attention paid to the latent functions or unanticipated consequences of these programs.

Environmental impact statements are now mandatory in areas where buildings, highways, recreational sites, etc. are being proposed. It is perhaps time to institute "human impact" studies, examining not only the manifest functions of programs, but following and evaluating carefully the latent consequences of

such programs. Only then can we decide whether or not we want to shape the lives of our aged population to conform to disengagement theory or a very restrictive view of activity theory.

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